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made. The inflation factor used to update rates for that period will be .5% for urban hospitals and 1.5% for rural hospitals.

9. Case Mix Adjustments for Base Year Operating Cost Per Discharge Rate

   a. The Department will adjust the operating cost per discharge rate to account for case-mix changes, based on the classification of inpatient hospital discharges according to the Diagnostic Related Group (DRG) methodology established and used by the Medicare program.

   b. For each DRG, the Department determines a relative value (the DRG relative weight) which reflects the charges for hospital resources used for the DRG relative to the average charges of all hospital cases. The Department's methodology for computing DRG relative weights was discussed earlier in Section III, subsection B. Case-mix adjustments will be computed using the methodology described below:

      Case-Mix Computation

      Each base year, a hospital's case-mix index will be computed by the Department and its fiscal agent as follows:

      - All Title XIX discharges are assigned to appropriate DRGs.

      - The case-mix index is computed for each hospital by summing the products of the case frequency and its DRG weight and dividing this sum by the total number of Title XIX cases at the hospital.

      The case-mix adjustment is applied to the base year operating cost per discharge as described in Section III.C.10.d below.

10. Limitations on Operating Cost Prospective Per Discharge Rates

   a. Limitations on operating cost prospective base rates will be imposed using a peer group methodology. Effective October 1, 1989, hospitals will be placed in one of six possible peer groups

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(Teaching, Referral, Regional, Low-volume Regional, Community and Low-volume Community) based on the following criteria: bed size, case-mix, services available, population served, location, trauma designation, teaching status, and low-volume (i.e. less than 150 Medicaid discharges per year.)

At the time of the next rebasing year following October 1, 1989, the criteria regarding low-volume will be dropped along with the low-volume peer groups, thus leaving four possible peer groups for assignment. (Teaching, Referral, Regional and Community).

b. The Department will determine the peer group assignment of each hospital, and appeal of such assignment will be allowed only as described in Section III.D.1 of this plan.

c. A ceiling on allowable operating costs will be set at 110 percent of the median of costs for all hospitals in the peer group, after application of each hospital's case mix and indexing of the cost from the hospital's fiscal year end to a common point of December 31. These adjustments are made to equalize the status of each hospital for ceiling establishment purposes. The median shall be the midpoint of rates (or the average of the rates of the two hospitals closest to the midpoint).

d. The case-mix equalization for each hospital in a peer group will be calculated as follows:

$$PGR = \frac{BYOR}{CMI}$$

PGR = Hospital rate equalized for peer group comparison
BYOR = Base year operating cost per discharge
CMI = Case mix index in the base year

e. The allowable operating cost per discharge rate (hospital-specific rate) will be the lower of:

° The ceiling for the hospital's peer group; or

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- The hospital rate resulting from the computation found in Section III.C.10.d. above.

11. Computation of Prospective Operating Cost Per Discharge Rate

The following formulas are used to determine the prospective operating cost per discharge rate for Years 1, 2, and 3:

Year 1

PD01 = HSR x (1 + MPPUF)

PD01 = Per discharge operating cost rate for Year 1

HSR = The hospital-specific rate, which is the lower of the peer group ceiling or the hospital's rate, equalized for peer group comparison

MPPUF = The applicable Medicare prospective payment update factor as described in Section III.C.8

Year 2

PDO2 = PDO1 x (1 + MPPUF)

PDO2 = Per discharge operating cost rate for Year 2
PDO1 = Per discharge operating cost rate for Year 1
MPPUF = The applicable Medicare prospective payment update factor as described in Section III.C.8

Year 3

PDO3 = PDO2 x (1 + MPPUF)

PDO3 = Per discharge operating cost rate for Year 3
PDO2 = Per discharge operating cost rate for Year 2
MPPUF = The applicable Medicare prospective payment update factor as described in Section III.C.8

12. Computation of Excludable Cost Per Discharge Rate

Total Medicaid excludable cost, as identified in Public Law 97-248 (TEFRA), with excludable capital costs reduced as indicated in Section III.C.3, will be paid in the following manner:

a. An excludable cost per discharge rate is computed

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using the following methodology:

ER = ECP/DCY

ER = Excludable Cost Per Discharge Rate
ECP = Excludable costs on the hospital's most recently settled cost report prior to the rate year, as determined by the audit agent
DCY = Medicaid discharges for the calendar year prior to the rate year, as determined by the Department's fiscal agent

b. The retrospective settlement will be determined based on the actual allowable amount of Medicaid excludable costs incurred by a hospital during the hospital's fiscal year.

13. Computation of Prospective Per Discharge Rate

The excludable cost per discharge, as described in Section III.C.12 above, will be added to the appropriate operating per discharge rates to determine the prospective rates.

14. Effective Dates of Prospective Rates

Rates will be effective for implementation October 1, 1989 and effective thereafter as of October 1 of each year for each hospital.

15. Effect on Prospective Payment Rates of a Change of Hospital Ownership

When a hospital is sold or leased, no change is made to the hospital's per discharge rate as a result of the sale or lease transaction.

16. Rate Setting for Border-Area Hospitals

Border-area hospitals will be reimbursed at median rate (including excludable cost pass-throughs) for the Regional peer group.

D. Changes to Prospective Rates

1. Appeals

Hospitals may appeal for a change in the operating component of the prospective payment rate, including a

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change in peer group assignment, as applicable. For an appeal to be considered, the hospital must demonstrate in the appeal that:

a. The following five requirements are satisfied:

1) The hospital inpatient service mix for Medicaid admissions has changed due to a major change in scope of facilities and services provided by the hospital.

2) The change in scope of facilities and services has satisfied all regulatory and statutory requirements which may be applicable, such as facility licensure and certification requirements and any other facility or services requirements which might apply.

3) The expanded services were a) not available to Medicaid patients in the area or b) are now provided to Medicaid patients by the hospital at a lower reimbursement rate than would be obtained in other hospitals providing the service.

4) The magnitude of the proposed (as appealed) prospective per discharge rate for the subsequent year will exceed 105 percent of the rate that would have otherwise been paid to the hospital.

5) In addition to requirements 1-4 above, appeals for rate adjustment will not be considered if cost changes are due to changes in hospital occupancy rate, collective bargaining actions, changes in hospital ownership or affiliation, or changes in levels of rates of increases of incurred cost items which were included in the base rate.

b. The appeal must provide a specific recommendation(s) regarding the magnitude of alterations in the appellant's prospective rate per discharge and peer group reassignment, as applicable. In making its decision on any appeal, the Department shall be limited to the following options:

1) Reject the appeal on the basis of a failure of the appellant to demonstrate necessary

conditions and documentation for an appeal as specified in 1.a. above; or

2) accept all of the specific recommendations, as stated in the appeal, in their entirety; or

3) adopt modified versions of the recommendations as stated in the appeal; or

4) reject all of the recommendations in the appeal.

c. Hospitals are limited to one appeal per year, which must be filed in writing by a duly authorized officer of the hospital no later than July 1 of each year. Within 15 calendar days of the filing date, the Department shall offer the appellant the opportunity for hearing of the appeal. If such a hearing is requested, it shall occur within 30 days of the filing date. The Department shall notify the appellant of the decision of the appeal in writing no later than September 15 of the year in which the appeal is filed.

E. Retroactive Settlement

1. Retroactive settlement may occur in those cases in which no audited cost reports were available at the time of rate setting and an interim rate was used. Retroactive settlement will only occur in those cases where adjustments to interim rates are required.

The Department's audit agent will determine the difference between payments to the hospital under the interim operating cost per discharge rate and what these payments would have been under the final rate. The audit agent will report the amount of overpayment or underpayment for each facility within 90 days of the effective date of the final rate. Retroactive settlements will be based on actual claims paid while the interim rate was in effect.

2. Underpayments: In the event that the interim rate is less than the final rate, the Department will include the amount of underpayment in a subsequent payment to the facility within 30 days of notification of underpayment.

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3. Overpayments: In the event that the interim rate exceeds the final rate, the following procedure will be implemented:

   The facility will have 30 days from the date of notification of overpayment to submit the amount owed to the Department in full. If the amount is not submitted on a timely basis, the Department will begin withholding from future payments until the overpayment is satisfied in full.

4. Retroactive settlements for excludable costs will be handled in the same manner as described above.

F. Special Prospective Payment Provisions

1. Outlier Cases

   Effective for discharges occurring on or after April 1, 1992, outlier cases are defined as those cases with medically necessary services exceeding $100,000 in billed charges, or those with medically necessary lengths of stay of 75 days or more, when such services are provided to children who have not attained the age of six years in disproportionate share hospitals, and to infants under age one in all hospitals. These cases will be removed from the DRG payment system and paid at an amount equal to 90% of the hospital's standardized cost. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio as calculated from the hospital's most recent cost report.

   Utilization review will be performed on all outlier cases to determine the medical necessity of services rendered. Should this review determine non-medical necessity for all or part of the services, these services will be deducted from the billed amount prior to payment.

2. Payment for Transfer Cases

   a. All cases transferred from one acute care hospital to another will be monitored under a utilization review policy to ensure that the Department does not pay for inappropriate transfers.

   b. The following methodology will be used to reimburse the transferring and discharging hospitals for appropriate transfers if both hospitals and any hospital units involved are

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included in the PPS:

1) A hospital inpatient shall be considered "transferred" when he or she has been moved from one acute inpatient facility to another acute inpatient facility. Movement of a patient from one unit to another unit within the same hospital shall not constitute a transfer, unless the patient is being moved to a PPS exempt unit within the hospital.

2) The transferring hospital will be paid the lesser of standardized costs or the appropriate DRG payment amount. Should the stay in the transferring hospital qualify for an outlier payment, then the case will be paid as an outlier as described in III.F. of this plan. Standardized costs are determined by multiplying the hospital's allowable billed charges by the hospital's cost-to-charge ratio.

3) The receiving hospital which ultimately discharges the patient will receive the full DRG payment amount, or if applicable any outlier payments associated with the case. All other hospitals which admitted and subsequently transferred the patient to another acute care hospital during a single spell of illness shall be considered transferring hospitals.

c. If the transferring or discharge hospital or unit is exempt from the PPS, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or unit.

3. Payment for Readmissions

Readmissions occurring within 15 days of prior acute care admission for a related condition will be reviewed to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the Department.

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4. Payment for Inappropriate Brief Admissions

Hospital stays of up to two days in length will be reviewed for medical necessity and appropriateness of care. (Discharges involving healthy mothers and healthy newborns are excluded from this review requirement). If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient discharge will be denied. If the inpatient claim is denied, the hospital is permitted to resubmit an outpatient claim for the services rendered. Such review may be further focused to exempt certain cases at the sole discretion of the Department.

5. Payment for Non-Medically Warranted Days

a. Reimbursement for hospital patients receiving services at an inappropriate level of care will be made at rates reflecting the level of care actually received. The number of days covered by the Medicaid program is determined based only upon medical necessity for an acute level of hospital care.

b. When it is determined that an individual no longer requires acute-level care but does require a lower level of institutional care, and when placement in such care cannot be located, the hospital will be reimbursed for "awaiting placement" days. Reimbursement will be made at the weighted average rate paid by the Department in the preceding calendar year for the level of care needed. There is no limit on the number of covered "awaiting placement" days as long as those days are medically necessary. However, the hospital is encouraged to make every effort to secure appropriate placement for the individual as soon as possible. During "awaiting placement" days, no ancillary services will be paid, but medically necessary physician visits will be reimbursed.

6. Sole Community Hospital Payment Adjustment

Effective for the quarter beginning July 1, 1993, in-state acute care hospitals that qualify as Sole Community Hospitals are entitled to receive a sole community hospital payment adjustment in accordance with the provisions specified below:

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a. To qualify for a sole community hospital payment adjustment, an acute care hospital must meet the Medicare classification criteria for a sole community hospital as set forth at 42 CFR 412.92. The hospital must qualify for a sole community hospital designation in the month prior to the effective date for the sole community adjustment. If a hospital already has a sole community hospital designation from Medicare this designation will be accepted by the Medicaid program. If for some reason, the hospital elected not to apply for sole community hospital designation under Medicare but wishes to apply for Medicaid purposes only, such application must be made directly to the Medicaid program. The Medicaid program will review the application in accordance with the criteria contained at 42 CFR 412.92.

b. For an in-state acute care hospital that qualifies as a sole community hospital in accordance with paragraph (a) above, the Department will make a quarterly sole community hospital payment at the end of each quarter. For the initial payment year (July 1, 1993, through June 30, 1994), the payment is the amount specified under paragraph (c) below. For subsequent years, the amount will be the amount calculated under paragraph (d) through (f) below.

c. For the initial payment year, the sole community hospital payment amount will be equal to the amount the hospital received from county government, either through the County Indigent Claims Act or by mill levy revenues dedicated to supporting the hospital's operating expenses, for calendar year 1992 (the base year) plus the inflation factor described in §III.C.8. of this plan. Verification of the base year amount will be made from the official report of expenditures by each county. Hospitals will have the opportunity to challenge the amount by filing an appeal with the Department within 30 days from the date they receive notice from the state of their sole community payment amount. If the hospital qualifies for the sole community designation later than the effective date of this plan amendment, the Medicaid program will prorate the sole community payment adjustment for the first quarter from the date of qualification to the end of that